LEGAL ACTION CENTER

Legality of Denying Access to Medication Assisted Treatment In the Criminal Justice System

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Executive Summary

Introduction

This report examines the prevalence of opiate addiction in the criminal justice system, its devastating consequences, and the widespread denial of access to one of its most effective forms of treatment: medication assisted treatment ("MAT"). The report then analyzes the circumstances in which the denial of MAT violates Federal anti-discrimination laws and the United States Constitution.

Opiate Addiction and Lack of MAT Throughout the Criminal Justice System

An estimated 65% of individuals in United States prisons or jails have a substance use disorder, and a substantial number of these individuals are addicted to opioids. Rates are at least as high in all other phases of the criminal justice system. This enormous amount of substance use among individuals with criminal justice involvement has far-reaching consequences, including higher recidivism rates, harm to families and children of criminal justice-involved individuals, and negative public health effects, including the transmission of infectious diseases and overdose deaths.

Scientific research has firmly established that treatment of opiate dependence with medications (MAT) reduces addiction and related criminal activity more effectively and at far less cost than incarceration. MAT uses medications, such as methadone or buprenorphine, to normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions without the negative effects of short-acting drugs of abuse. Methadone maintenance treatment ("MMT") has been confirmed clinically effective for opioid dependence in more than 300 published research studies. The U.S. Department of Health and Human Services' National Institutes of Health ("NIH") Consensus Panel reported that MMT has "the highest probability of being effective" when combined with attention to medical, psychiatric and socio-economic issues, as well as drug counseling, and recommended that "[a]ll opiate-dependent persons under legal supervision . . . have access to [MMT] . . . ." A 2009 study found buprenorphine, a newer medication, at least as effective as methadone in a correctional setting. Numerous studies also have shown that MAT reduces drug use, disease rates, and criminal activity among opiate addicted persons.

Notwithstanding the clear benefits of MAT, many in the criminal justice system prohibit MAT, even when it is prescribed by a treating physician. For example, the vast majority of jails and prisons fail to offer MAT for ongoing maintenance treatment, and 77% of jails surveyed in 2004 failed to use a specific standardized treatment protocol for opiate detoxification. In addition, courts often require defendants to detoxify from methadone or buprenorphine treatment as a condition of participating in drug court or receiving an alternative to incarceration sentence. Or, they might require a defendant to attend a drug treatment program but not include MAT as an option. MAT is also prohibited by some probation and parole agencies.

There are varied reasons for the denial of access to MAT. Some criminal justice agencies have expressed concerns about costs and diversion, but others have declined to permit MAT because of a lack of understanding of the nature of addiction and MAT, including the belief that MAT is "substituting one addiction for another." Some agencies deny access to MAT pursuant to a policy

prohibiting the medical use of all controlled substances, and some correctional facilities do not offer screening, detoxification, or treatment of *any* form of addiction. Finally, MAT may be unavailable in some jurisdictions.

As a result of this denial of access to MAT, people relapse and experience the host of negative consequences associated with addiction, including return to criminal activity, illness, and even death from withdrawal-related complications, overdose and infectious diseases.

Legal Consequences of Denying Access to MAT

This report explores potential liability under Federal laws when criminal justice agencies (correctional facilities, courts, parole and probation) require individuals to detoxify from MAT and/or prohibit individuals from taking appropriate medications as part of their treatment even when prescribed by a treating physician. The report considers liability when the denied access is (1) pursuant to a flat policy; (2) made on an individual basis but in contravention of the recommendation by the criminal defendant's or incarcerated individual's doctor, and/or not based on objective medical evidence; and (3) pursuant to a larger policy prohibiting the use of any controlled substances.

Anti-Discrimination Laws

The Americans with Disabilities Act ("ADA") and Rehabilitation Act of 1973 ("Rehabilitation Act") prohibit discrimination on the basis of disability. The goal of these laws is to eliminate discrimination by requiring government agencies and others to objectively evaluate the ability of individuals with disabilities to participate in activities and programs, rather than evaluate on the basis of outmoded stereotypes and myths. To prevail on a claim for discrimination, an individual must prove that s/he (1) has a "disability"; (2) is "otherwise qualified" to participate in or receive the benefit of a public entity's services, programs, or activities; and (3) was either excluded from participation in, or denied the benefits of, such services, programs, or activities, or was otherwise discriminated against because of disability.

Individuals who have been denied MAT by the criminal justice system can meet all of these requirements. With respect to the first two requirements, it is well established that people who receive or need MAT for opiate addiction are "individuals with a disability," and that all criminal justice agencies and courts are subject to these anti-discrimination laws. Moreover, many individuals could show that they would be "eligible" for parole, probation, alternative sentencing, or prison health care but for their participation in MAT. Criminal justice agencies could only defeat this showing through objective evidence that individuals in MAT posed a "significant risk" to the health or safety of others. They would likely be unable to make this showing because there is no credible objective evidence that MAT patients pose a significant risk to the community. To the contrary, MAT increases public safety. In other contexts, courts have rejected speculative arguments about the risk that MAT patients and programs pose to communities. In correctional facilities, diversion and other safety concerns can be minimized through appropriate strategies.

These individuals also can meet the third requirement of a discrimination claim (denial of MAT was "because of" a disability) when a criminal justice agency (i) treated them differently from people without that disability ("disparate treatment"), (ii) had a neutral policy that disproportionately affected people with that disability ("disparate impact"), or (iii) failed to provide MAT as a "reasonable accommodation." A blanket policy prohibiting MAT constitutes "disparate treatment" discrimination because such policies leave no room

for the individualized analysis required under law. Even criminal justice agencies that deny MAT on a case-by-case basis engage in disparate treatment discrimination if they deny MAT based on stereotypes about people needing MAT instead of based on objective scientific evidence. While the ADA and Rehabilitation Act do not require correctional facilities to provide an individual's preferred choice of treatment, they do prohibit the denial of treatment for discriminatory reasons.

Denial of MAT pursuant to neutral policies that prohibit the use of all prescribed controlled substances also violates the ADA and Rehabilitation Act when such policies have a disparate impact on individuals with disabilities, or if the agency fails to make a "reasonable accommodation" in order to avoid discrimination. Criminal justice agencies could only defeat these claims by showing that the neutral policies are necessary for the provision of the program offered or that modification of the neutral policy would "fundamentally alter" the nature of the program – showings that would be difficult to make for the reasons discussed above.

Constitutional Violations

Many courts have held that failure to provide incarcerated individuals with appropriate medical treatment for their withdrawal symptoms from opiate addiction could violate the United States Constitution's Eighth Amendment prohibition on cruel and unusual punishment (applicable to prisons) or Fourteenth Amendment Due Process Clause (applicable to jails). While the law is not as clear that the failure to provide MAT as ongoing treatment violates the Constitution when individuals are provided medically supervised detoxification, there is potential liability, and relevant Constitutional jurisprudence is evolving.

Conclusion

Denial of access to MAT at any level of the criminal justice system violates the ADA and the Rehabilitation Act where the denial is pursuant to a blanket policy prohibiting MAT or is carried out on a case-by-case basis without the required objective, individualized evaluation. The denial of MAT pursuant to a policy prohibiting the use of any prescribed controlled substance also is likely to violate the ADA and Rehabilitation Act due to its disparate impact on opiate-addicted individuals receiving or in need of MAT or if the agency fails to grant MAT as a "reasonable accommodation." Prisons and jails also risk violating the United States Constitution's Eighth Amendment prohibition on cruel and unusual punishment or Fourteenth Amendment Due Process clause when they force individuals on MAT to detoxify without appropriate medical supervision or delay the provision of MAT.

I. INTRODUCTION

The American Association for the Treatment of Opioid Dependence ("AATOD") asked the Legal Action Center to write a report on the legality of criminal justice agencies' denial of access to methadone maintenance and buprenorphine treatment for opiate addiction. AATOD and the Legal Action Center both have had a longstanding interest in expanding the use of these medications in criminal justice settings. This paper explains the prevalence of opiate addiction in the criminal justice system, the limited availability of methadone maintenance and buprenorphine treatment as well as the causes and consequences of policies and practices that make it nearly impossible for opiate addicted individuals to receive such treatment. The paper then analyzes how those policies and practices violate Federal anti-discrimination laws protecting individuals with disabilities and, in jails and prisons, how they violate the United States Constitution.

II. FACTUAL BACKGROUND

A. Opiate Addiction in the Criminal Justice System

An estimated 65% of individuals in United States prisons or jails have a substance use disorder,[1] and an additional 20% of individuals in United States prisons are substance involved.[2] For many years, the percentage of incarcerated individuals with substance use disorders and other substance involvement has been rising at a level disproportionate to the overall rise in the United States prison population.[3] A substantial number of incarcerated individuals with substance use disorders are addicted to opioids, such as heroin and prescription pain medication. In 2000, for example, a median of 5.6% of adult male arrestees and 6.6% of adult female arrestees tested positive for opiates at arrest, with the numbers much larger in some urban areas (a range of 10% to 27% in ten of thirty-five urban areas sampled).[4] An estimated 9% of all individuals in state prisons and jails were using opiates in the month prior to incarceration, and an estimated 12% of individuals in jails and 15% of individuals in state prisons have used opiates regularly at some point.[5] The percentages of people with substance use disorders at all other phases of the criminal justice system are at least as

[1] The Nat'l Ctr. for Addiction and Substance Abuse at Columbia Univ. ("CASA"), *Behind Bars II: Substance Abuse and America's Prison Population* i (Feb. 2010).
[2] CASA, *supra* note 1, at i ("substance involved" includes individuals who were under the influence of alcohol or other drugs at the time of their offense, stole money to buy drugs, abuse substances, and/or violated drug or alcohol laws).
[3] CASA, *supra* note 1, at 9.
[4] Colleen O'Donnell, M.S.W. & Marcia Trick, M.S., Nat'l Ass'n of State Alcohol and Drug Abuse Directors, Inc., *Methadone Maintenance Treatment and the Criminal Justice System* 4 (Apr. 2006).
[5] Duncan Smith-Rohrberg et al., *Research Note – Review of Corrections-Based Therapy for Opiate-Dependent Patients: Implications for Buprenorphine Treatment Among Correctional Populations*, 43 J. of Drug Issues 2 at 452 (Apr. 2004) (citing Bureau of Justice Statistics, U.S. Dep't of Justice, *Correctional Population of the United States, 1997*, (U.S. Dep't of Justice, NCJ-177613, 2000); C.W. Harlow, Bureau of Justice Statistics, U.S. Dep't of Justice, *Profile of Jail Inmates in 1996*, (U.S. Dep't of Justice, NCJ-164620, 1998)).

high, and often higher. For example, 69% of probationers reported past drug use, with 32% reporting illegal drug use in the month before their offense.[6] `

The enormous amount of substance use among individuals with criminal justice involvement has far-reaching consequences. Substance use has been clearly linked to the commission of crimes. For the overwhelming majority of incarcerated individuals, substance involvement was a factor in their crimes.[7] Recidivism rates are higher among incarcerated individuals with substance involvement than among other incarcerated individuals: in 2006, 53.4% of incarcerated individuals with substance involvement were re-incarcerated, as opposed to 38.9% of other incarcerated individuals.[8] Substance use among incarcerated individuals also impacts families and children. In 2006, it is estimated that 1 million substance involved parents, with 2.2 million minor children, were incarcerated in U.S. prisons and jails, leading to significant negative effects on children and families.[9] Substance use in United States jails and prisons also impacts broader public health issues. Both methadone and buprenorphine have been found to reduce health problems linked to heroin use, including the transmission of infectious diseases and overdose deaths.[10]

B. Methadone Maintenance and Other Forms of Medication Assisted Treatment

Scientific research has firmly established the success of drug treatment in reducing addiction and criminal activity more effectively and at far less cost than incarceration.[11] This includes addiction treatment that utilizes medications that have been proven effective for treatment of opioid dependence (commonly called "Medication Assisted Treatment," or "MAT"), such as methadone and buprenorphine.[12] MAT uses "agonist" or "partial agonist" medications, such as methadone or buprenorphine, to normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions without the negative effects of the short-acting drugs of abuse.

Methadone maintenance treatment ("MMT") has been available for over 40 years and has been confirmed clinically effective for opioid dependence in more than 300 published research studies. In 1997, the U.S. Department of Health and Human Services' National Institutes of Health ("NIH") Consensus Panel found that "[o]f various treatments available, *methadone maintenance treatment*, combined with attention to medical, psychiatric and socio-economic issues, as well as drug counseling, *has the highest probability of being effective*."[13] The NIH report also recommended that

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[6] Christopher J. Mumola & Thomas P. Bonczar, Bureau of Justice Statistics, *Substance Abuse Treatment of Adults on Probation, 1995* at 1, 3 (U.S. Dep't of Justice, 1998).
[7] *See, e.g.,* CASA, *supra* note 1, at 12.
[8] CASA, *supra* note 1, at 19.
[9] CASA, *supra* note 1, at 34.
[10] CASA, *supra* note 1, at 45.
[11] *See, e.g.,* Ctr. for Substance Abuse Treatment, U.S. Dep't of Health and Human Services, *Cost Offset of Treatment Services* (Apr. 2009).
[12] While the term MAT encompasses forms of treatment in addition to methadone and buprenorphine, this report will use the term MAT only as referring to the use of methadone and buprenorphine to treat opiate addiction. When describing case law that involved methadone maintenance only (and not buprenorphine), the report will use the term "MMT" for "methadone maintenance treatment."
[13] Nat'l Inst. of Health, *Effective Treatment of Opiate Addiction*, 15 NIH Consensus Statement 6 (Nov. 17-19, 1997) (emphasis added).

"[a]ll opiate-dependent persons under legal supervision should have access to [MMT] and the U.S. Office of National Drug Control Policy ["ONDCP"] and the U.S. Department of Justice ["DOJ"] should take the necessary steps to implement this recommendation."[14] The Office of National Drug Control Policy has also described methadone as a "rigorously well-tested medication that is safe and efficacious for the treatment of narcotic withdrawal and dependence."[15] A 2009 study found buprenorphine at least as effective as methadone, when administered in a correctional setting.[16] The National Institute on Drug Abuse ("NIDA") found that both methadone and buprenorphine "have been shown to help normalize brain function" for individuals addicted to heroin.[17] A number of studies have shown buprenorphine to be effective in managing opiate withdrawal and dependence.[18]

MAT in the criminal justice system would reduce costs in addition to improving health care. While MAT costs about $4,000 per person each year, incarceration in United States prisons has an average annual cost of $22,279.[19] Numerous studies also have shown that MAT reduces drug use and criminal activity among opiate addicted persons, "with effects many times the size of hospital-based detoxification, drug-free outpatient treatment, and residential treatment." [20]

C. Denial of Access to Medication Assisted Treatment in the Criminal Justice System

Notwithstanding the clear benefits of MAT, many in the criminal justice system – including some drug court judges, prosecutors, parole and probation agencies and officers, and jails and prisons – refuse to allow people addicted to heroin and other opiates to receive medications for their addiction, even when prescribed by a treating physician.

Jails and prisons

MAT is particularly unavailable in jails and prisons, even for those individuals already enrolled in MMTs upon their incarceration. Jails and prisons (and anyone else) may only provide MMT if registered with the U.S. Drug Enforcement Agency ("DEA") as a narcotic treatment program. But even without registering with the DEA, methadone may be provided to relieve acute withdrawal symptoms for up to three days.[21]

A 2005 national survey of jail administrators found that 85% did not continue methadone for individuals incarcerated in their jails who were previously participants in community MMT programs. Only 27% of jails routinely contacted the community program about the incarcerated

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[14] Nat'l Inst. of Health (1997), *supra* note 13.
[15] Erin Steiner Broekhuysen, Drug Policy Info. Clearinghouse, Office of Nat'l Drug Control Policy, *Fact Sheet: Methadone*, (Exec. Office of the President of the U.S., NCJ-175678, Apr. 2000).
[16] *See* CASA, *supra* note 1, at 45 (citing Stephen Magura et al., *Buprenorphine and Methadone Maintenance in Jail and Post-Release: A Randomized Clinical Trial*, 99 Drug and Alcohol Dependence 1-3 at 222-230 (Jan. 2009)).
[17] Nat'l Inst. on Drug Abuse, U.S. Dep't of Health & Human Services, *Principles of Drug Abuse Treatment for Criminal Justice Populations* 5 (Nat'l Inst. of Health, NIH Pub. No. 06-5316, Sept. 2006).
[18] *See* Smith-Rohrberg et al., *supra* note 5, at 460.
[19] O'Donnell & Trick, *supra* note 4, at 5 (citing M. Rosenbaum et al., *Treatment as Harm Reduction, Defunding as Harm Maximization: The Case of Methadone Maintenance*, 28 J. of Psychoactive Drugs 3 at 241-249 (1996); Crim. Justice Inst., *Corrections Yearbook: Adult Corrections 2002* 105-06 (Camille Graham Camp ed., 2002)).
[20] O'Donnell & Trick, *supra* note 4, at 5 (citing D.B. Marlowe, *Integrating Substance Abuse Treatment and Criminal Justice Supervision Science and Practice Perspectives* 4-14 (2003) (referencing the work of J.J. Platt et al., 1998)).
[21] 21 C.F.R. § 1306.07.

individuals under their care. Even though 62% of respondents said there was a MMT in their community, only 56% routinely asked individuals incarcerated in jails whether they were opiate addicted. Only 8% reported referring opiate-dependent individuals incarcerated in jails to methadone programs upon their release. Methadone was primarily reserved in jails for incarcerated women who were pregnant.[22]

Not only do the vast majority of jails and prisons fail to offer MAT for ongoing maintenance treatment, but most jails surveyed in 2004 (77%) also failed to use a specific standardized treatment protocol for opiate detoxification. Only 2% used methadone or other opiates, roughly half provided clonidine for withdrawal symptoms, 30% used only ibuprofen or acetaminophen, and 20% reported providing no symptomatic treatment.[23] Buprenorphine is offered in only seven correctional facilities in the United States, to an estimated maximum of 150 individuals total.[24] Of the 65% of incarcerated individuals with substance use disorders, only 11% received any type of professional treatment in 2006, and less than 1% received detoxification services.[25] Only 28% received other addiction-related services, such as peer counseling and education.[26] A 2007 study found that an average of only 5.9% of correctional facilities was using evidence-based practices, and that average dropped to 1.6% for local jails.[27]

The failure to provide appropriate medically supervised detoxification conflicts with standards in the Federal Bureau of Prisons ("FBOP") Clinical Practice Guidelines ("CPG") for Detoxification of Chemically Dependent Inmates. These guidelines call for careful screening practices as well as safe and effective treatment of withdrawal symptoms.[28] In particular, they authorize the use of methadone treatment for detoxification if the prison has the appropriate license, as well as clonidine as an acceptable alternative to methadone. The guidelines state that buprenorphine can be used in an outpatient setting but that is "is not routinely used in the [Federal Bureau of Prisons]."[29] The FBOP's recommendation for careful screening and detoxification is consistent with the National Commission on Correctional Health Care standards for drug treatment in jails.

Notably, however, the FBOP CPG does not make any recommendations with respect to methadone maintenance treatment. It simply states that "[m]edical detoxification is considered the standard of care for individuals with opiate dependence."[30] The only exception is for pregnant women, whom the guidelines recommend be treated with or maintained on methadone because detoxification increases the risk of miscarriage and premature labor.[31] Buprenorphine, however, is prohibited as maintenance therapy.[32] The educational sheet the FBOP recommends giving to patients who have been prescribed opiates states that "your medical team will develop a new treatment

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[22] Kevin Fiscella et al., *Jail Management of Arrestees/Inmates Enrolled in Community Methadone Maintenance Programs*, 81 J. of Urban Health: Bulletin of N.Y. Acad. of Med. 4 at 645-654 (2004)).
[23] O'Donnell & Trick, *supra* note 4, at 7 (citing Fiscella et al. (2004), *supra* note 23, at 645-654).
[24] CASA, *supra* note 1, at 45.
[25] *Id*. at 39-40.
[26] *Id.* at 40.
[27] *Id.* at 43.
[28] Fed. Bureau of Prisons, *Clinical Practice Guidelines: Detoxification of Chemically Dependent Inmates* 14-16 (Aug. 2009).
[29] *Id.* at 16.
[30] *Id.* at 14.
[31] *Id.*
[32] Fed. Bureau of Prisons, U.S. Dep't of Justice, *Health Services National Formulary* 9 (2010).

plan…that does not require the use of addictive medications," including working with psychology staff and/or drug treatment counselors and possible Narcotics Anonymous meetings.[33]

Parole and probation

Individuals on probation and parole also have limited access to MAT for opiate addiction. A 1995 Department of Justice study of the drug treatment programs offered to a representative sample of probationers across the country showed that MMT was one of the least common drug treatment options available: only 0.3% of probationers received MMT even though 6% of arrestees tested positive for opiates in 2000.[34] In 2003, a Virginia woman was sentenced to three years in state prison for violating a probation condition that prohibited her from taking methadone.[35]

Drug courts and other sentencing courts

Drug courts provide intensive, community-based treatment and case management for individuals convicted of drug offenses in lieu of prosecution or incarceration, and the National Drug Court Institute ("NDCI") and National Association of Drug Court Professionals ("NADCP") have strongly recommended use of MMT in drug courts.[36] Yet the obstacles to receiving MMT through drug courts are well documented. At the 2003 NADCP training conference, an overwhelming majority of attendees at a plenary session on Medical Management of Drug Abuse answered "yes" when asked whether they believed that "taking methadone is trading one addiction for another." At a 2004 annual meeting of the New England Association of Drug Court Professionals, a discussion to educate judges about office-based opiate treatment revealed deep divisions about the appropriateness of MAT.[37] Anecdotes abound about individuals required to stop taking methadone as a condition of participating in a drug court. In 2000, Bradley Douglas Moore, a California drug court participant, died of a heroin overdose after a drug court judge ordered him to stop taking methadone.[38] Since then, California passed a law prohibiting judges from banning opioid replacement therapy.

In addition to drug courts, other criminal courts may require defendants to detoxify from methadone or buprenorphine treatment as a condition of receiving an alternative to incarceration sentence. Or, they might require a defendant to attend a drug treatment program but not include MAT as an option.

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[33] Fed. Bureau of Prisons (2009), *supra* note 28, at 32.
[34] O'Donnell & Trick, *supra* note 4, at 9 (citing Office of Justice Programs, U.S. Dep't of Justice, *2000 Arrestee Drug Abuse Monitoring Annual Report* 19 (2003), http://www.ncjrs.org/pdffiles1/nij193013.pdf).
[35] Peggy Fulton Hora, *Trading One Addiction for Another?*, 2 J. of Maintenance in the Addictions 4 at 71, 73-74 (2005) (citing *Va. Woman Jailed for Taking Methadone on Advice from Doctor*, Join Together Online (Aug. 23, 2004), http://www.jointogether.org/sa/news/summaries/reader/0,1854,574254,00.html).
[36] Mark W. Parrino, M.P.A. & Laura McNicholas, M.D., Ph.D., Nat'l Drug Court Inst., *Methadone Maintenance and Other Pharmacotherapeutic Interventions in the Treatment of Opioid Dependence*, 3 Drug Court Practitioner Fact Sheet 1 (Apr. 2000).
[37] *See* Hora, *supra* note 35, at 72.
[38] *Id.*

D. Reasons Criminal Justice Agencies Deny Access to Medication Assisted Treatment

The reasons for the denial of access to MAT at all levels of the criminal justice system vary. In some instances, the denial may be pursuant to a written or unwritten policy, and in others, may be on a case-by-case basis.

Jails and Prisons

Commentators have offered various reasons for the reluctance or refusal of jails and prisons to provide MAT, ranging from cost to lack of understanding of the nature of addiction and MAT to concerns about diversion.[39] As noted above, jails and prisons may only provide MMT if registered with the DEA, though they may use methadone to relieve acute withdrawal symptoms for up to three days without DEA registration.[40] Jails and prisons that are not registered to provide MMT sometimes arrange for incarcerated individuals to go to community-based providers to receive their MMT. Anecdotal evidence suggests that some jails and prisons do not offer MAT because their medical directors do not believe it is a valid form of treatment because they view it as "substituting one addiction for another." Because many jails and prisons do not offer any screening, detoxification, or treatment of other forms of addiction (e.g., alcoholism or addiction to drugs other than opiates),[41] the failures with respect to opiate addiction may in some instances be related to these across-the-board failures. Finally, some jails and prisons may deny access to MAT pursuant to a larger policy prohibiting the medical use of all controlled substances.

Drug courts and other sentencing judges, probation and parole

The reasons for denial of access to MAT by drug courts, sentencing judges, and judges (and others) imposing probation and parole conditions vary, but are often due to myths about MAT. Some judges may view opiate addiction as a social problem addressed best through abstinence, sharing the view of many that MAT "substitutes one addiction for another." For example, Judge Herrick in Albany County Drug Court told Henry Bartlett, the Executive Director of The Committee of Methadone Program Administrators of New York State, that he will not allow drug court participants to receive MAT because he "believes in recovery." The drug court judge in Nevada County, CA, who in 2000 ordered Bradley Douglas Moore to stop taking methadone, said "I do not claim to be an expert on methadone, but my understanding is that it's as …close to being as addictive as heroin….Our goal is to break the cycle of addiction."[42] It is possible that drug courts also might have policies that prohibit participants (or parolees or probationers) from taking any controlled substances (pursuant to a prescription or not). Of course, drug courts may be unable to include MAT as a treatment option because it is not available. For example, drug courts in urban (50%) or mixed (44%)

[39] In a 2005 study of 114 jail staff in a newly constructed jail in a large metropolitan area that did offer MMT, the researchers found that older, more educated staff were supportive of MMT, while younger, non-medical staff showed less support and knowledge about MMT. Some of the latter voiced animosity toward drug addicted people generally, and others expressed a philosophical aversion to substituting one drug for another as well as concerns about diversion.

[40] *Id.*

[41] *See generally* Kevin Fiscella et al., *Benign Neglect or Neglected Abuse: Drug and Alcohol Withdrawal in U.S. Jails*, 32 J. L. Med. & Ethics 129 (Spring 2004) (describing the failure of most fails to provide any drug/alcohol screening or detoxification services).

[42] *See* Hora, *supra* note 35, at 73.

settings where MMT is available in the community were more likely to use MMT than those in suburban (29%) or rural (14%) settings.[43]

E. Consequences of Denial of Access to MAT

The consequences of this denied access to MAT are that people relapse, experience the host of negative consequences associated with addiction including return to criminal activity, and get sick (and sometimes die) from withdrawal-related complications. The World Health Organization ("WHO") has recommended methadone maintenance as one aspect of its guidelines for preventing HIV transmission in prisons.[44] Numerous studies have demonstrated that MAT has positive effects on the prison environment.[45] According to WHO, all studies of prison-based MAT programs found that incarcerated opiate injectors who receive MAT inject significantly less frequently than those who do not.[46] Studies have also shown that retention in MAT is associated with reduced hepatitis C infection, and that decreased HIV infection correlates highly with the duration and stability of MAT participation.[47] In addition, evaluations have found that MAT participants have lower rates of post-release drug use,[48] and retention in MAT is linked to reduced mortality.[49] In Barcelona, a pilot MAT program reduced the use of non-sterile injecting equipment, increased the use of condoms in sexual relationships, and significantly reduced the number of overdoses.[50] Effective MAT is also associated with reduced recidivism.[51]

By contrast, a 1994 study showed that incarcerated individuals who were on MAT and were forced to undergo methadone withdrawal upon incarceration often returned to narcotic use, frequently within the prison system and by injecting.[52] Another study found that incarcerated individuals on MAT had a significantly reduced rate of drug-related institutional charges and spent significantly less time in involuntary segregation.[53] Although there is currently a dearth of similar research on buprenorphine outcomes, WHO believes that further study of buprenorphine in prisons will likely show benefits similar to those of methadone.[54]

Studies of prisons that provide detoxification rather than treatment have not been promising. In Ireland, the relapse rate for incarcerated individuals who had participated in a detoxification

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[43] O'Donnell & Trick, *supra* note 4, at 11.
[44] Global Programme on AIDS, World Health Org., *WHO Guidelines on HIV Infection and AIDS in Prisons* 6 (1993); *see also* World Health Org. ("WHO"), *Interventions to Address HIV in Prisons: Drug Dependence Treatments* 17 (2007).
[45] WHO (2007), *supra* note 44, at 15.
[46] *Id*. at 13.
[47] *Id*. at 13 (citing David S. Metzger et al., *Drug Abuse Treatment as AIDS Prevention*, 13 Public Health Rep. 1 (June 1998)).
[48] *Id*. at 14.
[49] *Id*.
[50] *Id*. (citing J. Boguna, in *Report of the 3rd European Conference on Drug and HIV/AIDS Services in Prison*, O. O'Brien (ed.) 68-70 (1997)).
[51] *Id*.
[52] *Id*. (citing D. Shewan et al., *Behavioural Change Amongst Drug Injectors in Scottish Prisons*, 39 Soc. Sci. Med. Vol. 11 at 1585-1586 (1994)).
[53] WHO (2007), *supra* note 44, at 15 (citing S.L. Johnson et al., *Research Report: Institutional Methadone Maintenance Treatment: Impact on Release Outcome and Institutional Behaviour* (Ottawa: Correctional Service Canada No. R-119, 2001)).
[54] *Id.*

program was 78% within 12 months, and high post-release death rates were reported.[55] In England, a study of incarcerated individuals whose community-begun MMT was disrupted upon incarceration found resulting physical and psychological problems and risks, and also increased injection drug use, use of non-sterile injection equipment, and subsequent transmission of blood-borne infections.[56]

III. LEGAL LIABILITY

This legal analysis will explore potential liability under Federal laws incurred by criminal justice agencies (jails, prisons, drug courts, other alternative to incarceration programs, parole and probation departments and judges who set probation and parole conditions) that require individuals to detoxify from MAT and/or prohibit individuals not currently enrolled in an MAT from enrolling.[57] The analysis will consider liability when the denied access is (1) pursuant to a flat policy; (2) made on an individual basis but in contravention of the recommendation by the criminal defendant's or incarcerated individual's doctor, and/or not based on objective medical evidence; and (3) pursuant to a larger policy prohibiting the use of any controlled substances. The analysis also will evaluate whether liability changes if the individual is offered any other form of drug treatment and, in the case of jails and prisons, whether the incarcerated individual is provided medically supervised detoxification.

A. The Denial of Medication Assisted Treatment Throughout the Criminal Justice System Violates Federal Anti-Discrimination Laws

1. Background

Two Federal laws prohibit discrimination on the basis of disability – the Americans with Disabilities Act[58] ("ADA") and Rehabilitation Act of 1973[59] ("Rehabilitation Act" or "RA"). Title II of the ADA ("Title II") prohibits discrimination by state and local governments,[60] and Section 504 of the Rehabilitation Act prohibits discrimination by Federally operated or assisted programs.[61] To the extent that state and local government programs receive Federal financial assistance, they, too, are subject to the Rehabilitation Act. As described below, these laws jointly prohibit criminal justice agencies at all levels of government from discriminating against opiate addicted individuals receiving or in need of MAT.

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[55] *Id.* at 16.
[56] *Id.* (citing R.A. Hughes, *"It's like having half a sugar when you were used to three" – Drug Injectors' Views and Experiences of Substitute Prescribing Inside English Prisons*, 10 Internat'l J. of Drug Pol. 6 at 455-466 (2000)).
[57] This report does not examine potential state law violations from the denial of MAT in the criminal justice system. Yet, individuals denied MAT could raise a number of claims, ranging from tort claims, such as intentional infliction of emotional distress, negligence and medical malpractice, to claims under state and city anti-discrimination laws and state constitutions.
[58] 42 U.S.C. §§ 12101 et seq.
[59] 29 U.S.C. §§ 701 et seq.
[60] 42 U.S.C. § 12132.
[61] 29 U.S.C. § 794.

Congress enacted the ADA and RA "to provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."[62] Together, they require employers, government-run programs, and places of public accommodation to treat individuals with disabilities equally and fairly, and to evaluate objectively their ability to participate in activities, employment and places of public accommodation, rather than evaluate on the basis of outdated stereotypes and myths about individuals with disabilities. The ADA and the RA also require these entities to make "reasonable accommodations" to enable full and fair participation by individuals with disabilities.

To prevail on a claim for disability discrimination under Title II of the ADA and the RA, an individual must prove that s/he (1) has a "disability"; (2) is "otherwise qualified" to participate in or receive the benefit of some public entity's services, programs, or activities; (3) was either excluded from participation in, or denied the benefits of, the public entity's services, programs, or activities, or was otherwise discriminated against by the public entity; and (4) such exclusion, denial of benefits, or discrimination was by reason of the individual's disability.[63]

Discrimination can be shown through disparate treatment (also called "intentional discrimination"), disparate impact, or failure to provide reasonable accommodation,[64] all of which are explained below. This report explains why the denial of access to MAT at different levels of the criminal justice system could constitute discriminatory treatment, disparate impact, and failure to provide a reasonable accommodation in violation of the ADA and Rehabilitation Act.

2. Prison health care, parole, probation, drug courts, and alternative sentencing programs are "programs or activities" subject to the ADA and Rehabilitation Act

Title II of the ADA applies to the "services, programs, or activities of a public entity…."[65] "Public entity" includes all state and local governments, as well as "any department, agency, special purpose district, or other instrumentality of a State or States or local government,"[66] and, therefore, includes state and local jails, prisons, courts, and parole and probation departments.

Many courts have found that prison programs, parole/probation decisions, and court decisions concerning alternative sentencing are "programs or activities" as defined by the ADA and Rehabilitation Act. In *Pennsylvania Dep't of Corrections v. Yeskey*, the Supreme Court held that Title II of the ADA applied to prisons.[67] Since then, many courts have ruled that the ADA applies to a prison's medical services as well as a wide array of other programs or services available in jails and prisons.[68] Likewise, courts have routinely held that decisions setting parole and probation conditions

[62] 42 U.S.C. § 12101(b).
[63] *Thompson v. Davis*, 295 F.3d 890, 895 (9th Cir. 2001) (*citing* 42 U.S.C. § 12132 (1994)).
[64] *Tsombanidis v. W. Haven Fire Dep't*, 352 F.3d 565, 573 (2d Cir. 2003).
[65] 42 U.S.C. § 12132.
[66] *Id.* at § 12131(1)
[67] *Pennsylvania Dep't of Corr. v. Yesky*, 524 U.S. 206, 210 (1999).
[68] *See, e.g., Kiman v. N.H. Dep't of Corr.*, 451 F.3d 274, 287 (1st Cir. 2006) (it is well settled that medical care in prisons is one of the "services, programs, or activities" covered by the ADA).

are "programs or activities" subject to Title II of the ADA. [69] Drug courts and alternative sentencing programs also must comply with the ADA.[70]

In sum, prison health care, parole, probation, alternative sentencing programs and drug courts run by a State or local government are subject to Title II of the ADA. If they are Federally operated or assisted, they also are subject to the Rehabilitation Act, as are Federal prisons, courts and other criminal justice agencies.

3. People who receive or need MAT for opiate addiction are "individuals with a disability," protected by the ADA and Rehabilitation Act

People who receive or need methadone maintenance or buprenorphine treatment for opiate addiction are *"individuals with a disability"* under Title II of the ADA and the Rehabilitation Act. The ADA provides three ways for an individual to establish disability – (1) a *current* physical or mental impairment that substantially limits one or more major life activities, (2) a *record* of such an impairment, or (3) being *regarded as* having such an impairment.[71] Therefore, if an individual currently has, or ever had, an impairment that substantially limits any major life activities, or is regarded by others as having an impairment, that individual is protected by the ADA.

Courts have routinely found that individuals in MAT who challenged discrimination were individuals with a disability under one or all prongs (current, record of, or regarded as disabled). For example, in *MX Group, Inc. v. City of Covington*,[72] a methadone maintenance treatment program charged the City of Covington with zoning discrimination based on the disability of its patients. The court noted that it is well established that drug addiction constitutes an "impairment" under the ADA and that drug addiction necessarily substantially limited the major life activities of "employability, parenting, and functioning in everyday life." [73] The court also found that the program's patients had a "record" of a substantially limiting impairment because in order to be admitted, individuals had to have had an addiction for at least one year, and trial testimony established that the types of individuals admitted to the programs included persons unable to work and function because of addiction.[74] Finally, the court found that individuals in MMT were "regarded as" having an impairment because the discrimination resulted from unfounded fears and stereotypes that recovering

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[69] *See, e.g., Thompson v. Davis*, 295 F.3d 890, 896-97 (9th Cir. 2002) (parole hearings are "public programs or activities" covered by Title II); *Robinson v. Hofbauer*, 2008 WL 324217, at *1 (W.D. Mich. Feb. 2, 2008) (agreeing with *Thompson*); *Bogovich v. Sandoval*, 189 F.3d 999 (9th Cir. 1999) (challenges that parole decisions violate Title II are appropriate); *Prater v. Caruso*, 2006 WL 2882350, at *3 (W.D. Mich. Oct. 5, 2006) (ADA and RA are applicable to state parole board decisions); *Ghashiyah v. Wis. Parole Comm'n*, 2006 WL 2690372, at *4 (E.D. Wis. Sept. 19, 2006) (parole board is subject to Title II of the ADA, citing *Yeskey*); *Webber v. Pa. Bd. of Prob. and Parole*, 2006 WL 581197, at *3 (M.D. Pa. Mar. 8, 2006) (same); *Giraldi v. Board of Parole*, 2008 WL 907321, at *5 (N.D.N.Y. Mar. 31, 2008) (same).

[70] *Galloway v. Super. Ct. of D.C.*, 816 F. Supp. 12, 15, 19 (D.D.C. 1993) (Super. Ct. of D.C. is a "public entity" under the ADA and RA); *People v. Brathwaite*, 11 Misc. 3d 918, 816 N.Y.S.2d 331 (Crim. Ct., Kings Cnty. 2006) (Brooklyn's alternative sentencing program falls under Title II's definition of "state service or program."); *Evans v. State*, 667 S.E.2d 183, 186 (Ga. App. 2008) (Towaliga Cir. Drug Ct. in Georgia is a "public entity" under the ADA).

[71] 42 U.S.C. § 12102(1).

[72] *MX Group, Inc. v. City of Covington*, 293 F.3d 326, 336 (6th Cir. 2002).

[73] *Id.* at 338.

[74] *Id.* at 339-40.

drug addicts would necessarily attract crime and drug activity to the area.[75] Courts addressing other zoning discrimination cases against programs providing MAT have made similar rulings.[76] Establishing disability was made even easier in 2009, when Congress amended the ADA to ensure that this definition of disability "shall be construed in favor of broad coverage."[77] Consequently, individuals who are denied access to MAT by the criminal justice system can readily establish that they are "individuals with a disability," protected by the ADA and Rehabilitation Act.

4. People receiving or in need of MAT for opiate addiction are "otherwise qualified" for (1) adequate health care in prisons and jails, (2) probation and parole, (3) drug courts and alternative sentencing programs

To be protected from discrimination under the ADA and RA, individuals with a disability must be "otherwise qualified" for the government services, programs or activities at issue. An individual is "qualified" if, "with or without reasonable modifications to rules, policies, or practices," the individual "meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by the public entity."[78] An individual, therefore, must prove that s/he is "eligible for the participation in the program sought."[79] To determine whether someone is "eligible," courts first ascertain the "service, program, or activity" at issue, and then determine its essential eligibility requirements.[80]

Several courts have ruled that individuals challenging disability-based discrimination by criminal justice agencies were "otherwise eligible" for the service, program, or activity at issue. In *Pennsylvania Dep't of Corrections v. Yesky*, for example, where incarcerated individuals sued the Department of Corrections for denying them admission to prison boot camp because of their disability (hypertension), the United States Supreme Court held that the term "qualified individual with a disability" can be applied to prisoners who are eligible for and seek access to prison programs.[81] For example, a "drug addict" convicted of drug possession might, as part of his sentence, be required to participate in a drug treatment program for which only individuals suffering from drug addiction are "eligible."[82] In another example, a Federal appeals court held that incarcerated individuals who charged the parole board with illegally denying them parole because of their

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[75] *Id.* at 340-42.
[76] *See, e.g., Start, Inc. v. Baltimore Cnty., Md.*, 295 F. Supp. 2d 569, 576-77 (D. Md. 2003) (reasonable to assume that individuals in MAT are "limited in their ability to work, raise children, care for themselves, and function in everyday life" and have a record of such an impairment); *Bay Area v. City of Antioch*, 2000 WL 33716782, at *6 -7 (N.D. Cal. Mar. 16, 2000) (individuals receiving MAT are still often substantially limited in their ability to work and raise a family and have a "record" of disability of untreated heroin addiction; also are regarded as disabled where defendants characterized patients as "engaging in criminal behavior and unable to control their anger" and opponents of clinic opined that MMT clients would continue to "abuse drugs and commit crimes").
[77] 42 U.S.C. § 12102(4)(A).
[78] 42 U.S.C. § 12131(2); 28 C.F.R. § 35.104; s*ee also* 45 C.F.R. § 84.3(k)(4) (same provision for RA).
[79] *Toney v. Goord*, 2006 WL 24966859, at *3 (N.D.N.Y. Aug. 28, 2006); *Kula v. Malani*, 539 F. Supp. 2d 1263, 1268 (D. Hi. 2008).
[80] *See Raines v. State*, 983 F. Supp. 1362, 1373 (N.D. Fla. 1997).
[81] *Pennsylvania Dep't of Corrections v. Yesky*, 524 U.S. 206 (1999).
[82] *Id.* at 210-11.

disability (drug addiction) sufficiently alleged that they were "otherwise qualified" for parole because they were statutorily eligible.[83]

With respect to denied access to MAT, there likely are prospective plaintiffs who could show that they would be eligible for parole, probation, drug court participation or other alternative sentencing program, but for their participation in MAT. With respect to prison health care, incarcerated individuals should be able to establish eligibility for whatever level of prison health care correctional facilities are required to provide pursuant to their governing laws, regulations, or policies (whether they be local, state or Federal).

Individuals challenging discrimination are not "otherwise qualified" if their participation in the service, program or activity at issue would pose a "significant risk to the health or safety of others by virtue of the disability that cannot be eliminated by reasonable accommodation."[84] Because the significant risk test is a "rigorous objective inquiry" that requires reliance on current medical knowledge or the best available objective evidence, and not subjective speculation, [85] courts are unlikely to find that individuals in MAT pose a "significant risk" in any of the criminal justice settings discussed in this report.

To disqualify an individual from protection under the ADA, the risk "must be substantial, not speculative or remote," and must not be based on "subjective judgments" of the individuals or officials supposedly at risk.[86] One court explained that the inquiry requires a "fact-intensive determination" taking into consideration four factors: "the nature, duration, and severity of the risk, and the probability that the potential injury will occur."[87] The inquiry must be based on "current medical knowledge" or "best available objective evidence," not on "stereotypes or generalizations."[88]

Numerous courts have rejected arguments by municipalities that patients who attend a community MAT program pose a significant risk to others. In a series of "not in my backyard" ("NIMBY") challenges to the siting of MAT programs, Federal courts have dismissed the purported rationales for excluding MAT programs, holding, for example, that "[g]eneralities about the criminal behavior of heroin addicts" do not provide enough specific information to establish the existence of a "realistic threat to the community."[89] In *New Directions Treatment Services v. City of Reading*, the court went through a detailed analysis of the evidence and ultimately rejected the defendant's assertion of a significant risk. The court found, for example, that the statement of one elected official,

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[83] *Thompson v. Davis*, 295 F.3d 890, 896 (9th Cir. 2002).
[84] *Start, Inc. v. Baltimore Cnty., Md., et al.*, 295 F. Supp. 2d 569, 577-78 (D. Md. 2003) (*quoting Doe v. Univ. of Md. Med. Sys. Corp.*, 50 F.3d 1261, 1264-65 (4th Cir. 1995)).
[85] *New Directions Treatment Serv. v. City of Reading*, 490 F.3d 293, 305 (3d Cir. 2007); s*ee also Start, Inc.*, 295 F. Supp. 2d at 578 (*quoting Montalvo v. Radcliffe*, 167 F.3d 873, 876-77 (4th Cir. 1999)).
[86] *New Directions Treatment Serv.,* 490 F.3d. at 306. The Department of Justice regulations implementing Title II of the ADA explain that "in determining whether an individual poses a direct threat to the health or safety of others, a public entity must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk." 28 C.F.R. § 35.139(b).
[87] *Start, Inc.*, 295 F. Supp. 2d at 578 (*quoting Montalvo v. Radcliffe*, 167 F.3d 873, 876-77 (4th Cir. 1999)) (internal quotations omitted).
[88] *Id.* (internal quotations omitted).
[89] *Id*. at 578-79.

who opposed the clinic in question, "betray[ed] the generalized prejudice and fear" that the ADA was meant to protect against.[90] Additionally, the court in *Bay Area v. City of Antioch* found no significant risk after also engaging in a detailed, fact-driven, witness-driven analysis to determine that plaintiffs' evidence was more "persuasive and substantial, and based on evidence and experience."[91]

Generalized fears about MAT patients have also been rejected in the employment context, most recently in a case brought by the United States Equal Employment Opportunity Commission ("EEOC"). In *Equal Employment Opportunity Commission v. Hussey Copper Ltd.*, the court let proceed a case challenging the termination of an employee because of his participation in MAT.[92] The employer argued that employing the plaintiff in a safety-sensitive position would pose a significant risk due to the plaintiff's participation in MAT. But the court highlighted evidence that the employment decision was based merely on "the speculation that there may be future manifestations of side effects" from the plaintiff's methadone use, and the ADA prohibits basing employment decisions on such speculation.[93]

Criminal justice agencies likely will be unable to establish that participation in MAT poses a significant risk in any of the challenged settings. In the context of drug courts, alternative sentencing programs, probation and parole, the significant risk defense should fail for the same reasons it fails in the NIMBY cases cited above. There is no credible evidence that MAT programs or their patients pose a significant risk to the community.

In prisons and jails, where officials may cite the risk of diversion of methadone and buprenorphine, individuals should be able to prove that their participation in MAT while incarcerated does not pose a significant risk. To minimize diversion, correctional facilities should employ the same strategies they use when dispensing other medications, including other controlled substances, i.e., maintain them in secure health facilities within the institution. Jails could transport inmates to community-based facilities to avoid concerns raised by dispensing methadone and buprenorphine within the jail. Individuals who brought suit could call as expert witnesses officials from those correctional facilities that successfully provide MAT to explain how the risk of diversion is ameliorated. The development of a buprenorphine 30- to 90-day implant (currently in clinical trials) would further reduce black market potential. And as noted on pages 7-8, numerous studies have demonstrated that MAT has positive effects on prison safety, including reduced injection drug use while incarcerated (as well as post-release), and reduced rates of drug-related institutional charges and amount of time incarcerated individuals spend in involuntary segregation. Reduced injection drug use in correctional facilities also could lessen the risk of needle-sticks faced by correctional officers searching cells or doing pat-downs.[94] Also discussed above (pp. 7-8), these safety outcomes are in addition to improved health outcomes, such as reduced hepatitis C and HIV infection and reduced mortality – outcomes not achieved by correctional facilities that merely provide detoxification.

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[90] *New Directions Treatment Serv.* 490 F.3d at 306-07.
[91] *Bay Area v. City of Antioch*, 2000 WL 33716782, *8-11 (N.D. Cal. Mar. 16, 2000); s*ee also Smith-Berch, Inc. v. Baltimore Cnty., Md.*, 68 F. Supp. 2d 602, 618 n.17 (D. Md. 1999) (finding no evidence in the record that the siting of a methadone program posed a significant risk that could not be eliminated by reasonable accommodation).
[92] *Equal Emp't Opportunity Comm'n v. Hussey Copper Ltd.*, 696 F. Supp. 2d 505 (W.D. Pa. 2010).
[93] *Id.* at 520-21.
[94] Jessica Wapner, *Giving Prisoners Addictive Drugs: Sometimes a Good Idea,* THE ATLANTIC (Apr. 25 2011), http://www.theatlantic.com/life/archive/2011/04/giving-prisoners-addictive-drugs-sometimes-a-good-idea/237823/.

5. Denial of Access to MAT in prisons, jails, drug courts, alternative sentencing programs, probation and parole is discrimination "because of" disability

Some individuals who are denied access to MAT in the criminal justice system could prove that the denial was "because of" disability (in violation of the ADA and Rehabilitation Act) rather than because of a neutral, non-discriminatory reason. Depending on the circumstances, the denial could constitute discrimination under any of the three bases: (1) disparate treatment, (2) disparate impact, (3) or failure to provide a reasonable accommodation.

a. Disparate treatment

Individuals denied access to MAT can win a claim for disparate treatment discrimination if they prove that they are being treated differently because of their disability. The reason for the differential treatment does matter. For example, it is irrelevant whether the differential treatment is due to animus against opiate addicted individuals receiving or in need of MAT, or because of good-intentioned, but ill-informed, opinion about the efficacy of MAT. As explained below, individuals who are denied MAT pursuant to a criminal justice institution's blanket policy prohibiting the use of MAT for opiate addiction should succeed in proving disparate treatment. Disparate treatment also exists when criminal justice agencies deny access to MAT to some (but not all) individuals without performing the individual inquiry required by the ADA.

i. Drug courts, alternative sentencing programs, probation and parole

Courts readily invalidate as discriminatory those policies or laws that categorically exclude or deny a benefit to individuals with disabilities, unless the defendant proves that the exclusionary criterion either is necessary to avert a significant risk (discussed above; also known as the "direct threat" defense), or is an essential component of the program. For example, in *Hargrave v. Vermont,* a Federal appellate court ruled that a Vermont law authorizing the state to override a health care proxy and forcibly medicate civilly committed and incarcerated individuals with mental illness – but not those who were physically ill – violated Title II of the ADA and the Rehabilitation Act.[95] Another Federal appellate court held that the categorical denial of parole because of an individual's past drug addiction was subject to ADA scrutiny.[96]

Likewise, conditioning participation in drug court, alternative sentencing programs, probation or parole on individuals' non-participation in MAT categorically excludes all opiate addicted individuals who receive or need MAT. While these courts and criminal justice agencies might argue that there is no categorical exclusion because these individuals may participate if they seek other forms of treatment, other forms of treatment are often not viable and run counter to the individuals' doctors' recommendations. Even when the requirement is not a categorical exclusion, but made on

[95] *Hargrave v. Vermont*, 340 F.3d 27 (2d Cir. 2003).
[96] *Thompson v. Davis*, 295 F.3d 890 (9th Cir. 2002).

case by case basis, it is discriminatory because no other individuals (with or without disabilities) are required to halt a prescribed treatment as a condition of participation in the drug court, alternative sentencing program, or probation or parole. Therefore, these individuals are being treated differently "because of" their disability. This argument would be particularly strong in the case of individuals who have been prescribed MAT and forced off or not allowed to begin, as opposed to those who have not yet been prescribed MAT.

Even without a blanket policy prohibiting MAT, courts or criminal justice agencies that deny access to MAT without conducting an individualized analysis violate the ADA if they are acting on the basis of stereotypes about people receiving or in need of MAT, or are otherwise treating such individuals differently "because of" their disability. This point was illustrated very strongly in a recent employment discrimination case, *Equal Employment Opportunity Commission v. Hussey*,[97] also discussed on page 13. In *Hussey*, the EEOC brought suit on behalf of a job applicant whose offer of employment was rescinded when the employer found out that the applicant was in an MMT program. The employer argued that the applicant was not qualified for the safety-sensitive position as a production laborer because of his MMT participation. The court denied the employer's request to dismiss the case and allowed it to proceed to trial to determine whether the employer engaged in the "necessary individualized assessment" of the applicant's ability to perform the job. Even though the company doctor who made the recommendation not to hire the applicant had spoken to the nurse who conducted the pre-employment physical and had some knowledge about MMT, the court noted that the doctor had never personally examined the applicant, had not asked the applicant about his own experience with methadone's effect on cognitive functions, and had not spoken to the applicant's prescribing physician. Moreover, the employer had no information to suggest that the applicant was suffering or had suffered from cognitive defects as a result of his MMT. Finally, the employer did not use a neuro-cognitive examination to assess applicant's ability to perform the job safely even though they had used it in the past and had it available. Instead, the employer "speculate[d] as to possible safety concerns which could have arisen . . . without any indication that [applicant's] methadone use actually impeded his ability to safely perform" the job.[98]

Similarly, individuals denied MAT – even if not pursuant to a blanket policy – likely would prevail in showing that the denial was "because of" disability if the court or criminal justice agency did not perform the type of individualized analysis laid out in *Hussey*. Any argument that an individual's participation in MAT would pose a significant risk to others would be defeated for the same reasons they have been defeated in the NIMBY cases, discussed above.

ii. Prisons and jails

Prisons and jails also violate the ADA and Rehabilitation Act when they deny access to MAT for discriminatory reasons ("because of" a disability). Though the ADA does not mandate the provision of health services and does not set a standard of care, services that are provided may not be rendered in a discriminatory fashion. One Federal appellate court clearly explained the standard for deciding whether prison health services are being applied in a discriminatory way:

[97] *Equal Emp't Opportunity Comm'n v. Hussey Copper Ltd.*, 696 F. Supp. 2d 505 (W.D. Pa. 2010).
[98] *Id.* at 517-18.

> . . . the physician's decision may have been so unreasonable in the sense of arbitrary and capricious – as to imply that it was pretext for some discriminatory motive, such as animus, fear, or apathetic attitudes. Or, instead, . . . a plaintiff may argue that her physician's decision was discriminatory on its face, because it rested on stereotypes of the disabled rather than an individualized inquiry…and was unreasonable in that sense.[99]

The reasons correctional facilities deny access to MAT vary (see pp. 6-7), as do the alternatives they offer. Some provide medically supervised detoxification using other medications, and some provide virtually no medical supervision of detoxification. Some provide follow up treatment without medications, and some provide no follow up treatment at all. Those that offer medically supervised detoxification and treatment without medication might argue than the ADA does not require them to give inmates their preferred choice of treatment and that a medical judgment they disagree with is not actionable under the ADA. While it is true that the ADA does not require correctional facilities to provide an incarcerated individual's preferred choice of treatment, the ADA does prohibit discriminatory policies, such as a blanket ban on the provision of MAT, that leave no room for individualized analyses.

If prisons and jails can prove that their prohibition on MAT is pursuant to a larger policy prohibiting the use of any prescribed controlled substances, and not due to differential treatment of opiate addicted individuals in need of MAT, some individuals could still prove discrimination through a reasonable accommodation claim, as discussed below. Correctional institutions likely will also argue that their denial of access to MAT is justified by security concerns. As discussed above (page 13), however, security concerns about diversion can be addressed through means other than prohibiting MAT.

b. Policies prohibiting the use of all controlled substances could violate Title II of the ADA and the Rehabilitation Act if MAT is not allowed as a "reasonable accommodation" or if the policy has a disparate impact on opiate addicted individuals who need MAT

In addition to prohibiting discrimination against any "qualified individual with a disability," Title II of the ADA requires government agencies to make "reasonable modifications" to their policies, practices, or procedures in order to avoid discrimination. This reasonable modification requirement applies unless the modifications would "fundamentally alter the nature of services, program, or activity."[100] If prisons, jails, drug courts, alternative sentencing programs, or probation or parole departments deny access to MAT because of a general policy prohibiting treatment with any controlled substance, potential plaintiffs could demonstrate that the failure to make a reasonable modification of the policy for individuals in need of MAT violates the ADA. Prisons and jails could only justify the denial of a reasonable modification if the provision of MAT would pose a direct threat or require a fundamental alteration in the program at issue. They would be unlikely to prevail with the direct threat defense for the same reasons discussed elsewhere in this report. Neither are they likely to be able to show that providing MAT would require a fundamental alteration of the program.

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[99] *Kiman v. N.H. Dep't of Corr.*, 45 F.3d 274 (1st Cir. 2006) (citations omitted).
[100] 28 C.F.R. § 35.130(b)(7).

The ADA's Title II regulations also prohibit government entities from imposing eligibility criteria "that screen out or tend to screen out" individuals with disabilities (i.e., have a disparate impact on such individuals) unless the criteria are necessary for the provision of the service, program, or activity offered.[101] Therefore, even a neutral eligibility criterion for participation in criminal justice programs, such as no use of prescribed controlled substances, violates the ADA and Rehabilitation Act if it "screens out or tends to screen out" opiate addicted individuals receiving or in need of MAT. Criminal justice agencies could only defeat such a claim by proving that the requirement is necessary for the program or activity. This would be a difficult showing to make for the same reasons discussed elsewhere in this report.

B. Forced Detoxification from MAT in Prisons and Jails can Violate the Eighth and Fourteenth Amendments to the United States Constitution

Prisons and jails that fail to provide MAT risk violating the United States Constitution's Eighth Amendment prohibition on cruel and unusual punishment (applicable to prisons) or Fourteenth Amendment Due Process Clause (applicable to jails). Many courts have held that failure to provide incarcerated individuals with appropriate medical treatment for their withdrawal symptoms from opiate addiction could violate these Constitutional provisions. In addition, one court has held that a delay in the provision of MAT could violate the Fourteenth Amendment, especially where there was insufficient medical supervision of the withdrawal experienced while awaiting methadone.[102] While the law is not as clear that the failure to provide MAT as ongoing treatment violates the Constitution when individuals are provided medically appropriate detoxification, there is potential liability, and relevant Constitutional jurisprudence is evolving.

Inadequate medical care in prisons violates the Eighth Amendment's prohibition against cruel and unusual punishment if the prison shows a "deliberate indifference" to an inmate's "serious medical needs."[103] In jails, courts apply a similar analysis as to whether inadequate medical care violates the Due Process Clause of the Fourteenth Amendment. Courts first ascertain whether there is a "serious medical need," which is generally understood as a need that was "diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention."[104] If there is a serious medical need, the court ascertains whether prisons' response to that need reflects "deliberate indifference" – meaning that the official knew of an "an excessive risk to inmate health or safety" and disregarded that risk.[105]

Several individuals have successfully shown that withdrawal from methadone or heroin is a "serious medical need," and that jails or prisons who did not provide methadone or other appropriate medical supervision of their withdrawal violated (or might have violated) the Eighth or Fourteenth Amendments.[106] In *Foelker v. Outagamie County*, for example, a Federal appellate court ruled that a

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[101] 28 C.F.R. § 35.130(b)(8).
[102] *See* cases cited on page 20.
[103] *See Estelle v. Gamble*, 429 U.S. 97, 103 (1976); *Farmer v. Brennan*, 511 U.S. 825, 828 (1994).
[104] *Monmouth Cnty. Corr. Institutional Inmates v. Lanzaro*, 834 F.2d 326, 347 (3d Cir. 1987).
[105] *Farmer v. Brennan*, 511 U.S. at 827.
[106] *See, e.g., Monmouth Cnty.*, 834 F.2d at 347; *Quatroy v. Jefferson Parish Sheriff's Office*, 2009 WL 1380196, at *9 (E.D. La., May 14, 2009)); *Foelker v. Outagamie Cnty.*, 394 F.3d 510, 513 (7th Cir. 2005); *Sylvester v. City of Newark*,

plaintiff who was receiving MAT at the time of his incarceration could ultimately prevail on his claim that jail employees violated the Fourteenth Amendment by forcing him to detoxify from methadone without proper medical supervision.[107] For four days, jail officials observed the plaintiff's withdrawal symptoms – including confusion, disorientation, hearing voices, and defecating on himself – but did not provide any treatment other than, on the third day, giving him a medication (thiamine) used for alcohol withdrawal. The court ruled that the jail employees' conduct could constitute "deliberate indifference."[108] Several other courts have reached the same result when incarcerated individuals were either forced off methadone without appropriate medical supervision or let to suffer withdrawal from heroin without appropriate medical supervision.[109] Those correctional facilities that provide appropriate medical supervision of detoxification have generally escaped liability.[110]

The same court that decided *Foelker* ruled, one year later, that even a jail that provides MAT could violate the Fourteenth Amendment when there is an inordinate delay providing it. The plaintiff in *Davis v. Carter*[111] was receiving MAT at the time of his arrest and requested methadone in jail. Five days later, he still had not received methadone and died of an unrelated aneurysm. During his five-day incarceration, jail employees observed his severe withdrawal symptoms, noted that the plaintiff looked "terrible" and "real bad," heard him complain to another inmate that his "stomach felt like somebody was ripping his insides out," and attempted to get him medical attention and methadone. The court found that a jury might reasonably conclude that the county "had a widespread practice or custom of inordinate delay in providing methadone treatment to inmates," which would violate the Fourteenth Amendment. In particular, there were no policies to ensure timely verification of an incarcerated individual's outpatient methadone treatment program, or to ensure that once such verification was obtained, incarcerated individuals were brought to the pharmacy within a reasonable time. In addition, the court held that the jury could find that jail employees showed deliberate indifference by failing to get the plaintiff medical attention for his withdrawal.[112]

In sum, inmates who are detoxified from MAT or let to suffer withdrawal from heroin or other opiates without appropriate medical supervision and experience serious medical complications have a strong claim that the jail or prison violated the Eighth or Fourteenth Amendments of the Constitution. Delays in providing MAT without treating the resulting withdrawal also could violate the Constitution.

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120 Fed. Appx. 419, 423 (3d Cir. 2005); *Gonzales v. Cecil Cnty., Md.*, 221 F. Supp. 2d 611, 616 (D. Md. 2002); *Anderson v. Benton Cnty.*, 2004 WL 2110690 (D. Or., Sept. 21, 2004).

[107] *Foelker v. Outagamie County,* 394 F.3d 510 (7th Cir. 2005).

[108] *Id.* at 513.

[109] *See, e.g., Quatroy v. Jefferson Parish Sheriff's Office*, 2009 WL 1380196 (E.D. La., May 14, 2009); *Messina v. Mazzeo*, 854 F. Supp. 116 (E.D.N.Y. 1994); *U.S. ex rel. Walker v. Fayette Cnty.*, 599 F.2d 573, 574 (3d Cir. 1979) (*per curiam*).

[110] *See, e.g., McNamara v. Lantz,* 2008 WL 4277790 (D. Conn., Sept. 16, 2008) (no Fourteenth Amendment violation where jail officials gave inmate drugs other than methadone to treat withdrawal symptoms and monitored him); *Bovet v. County of Washington*, 2006 WL 3422104 (D. Utah, Nov. 28, 2006) (same); *Samford v. Bowers*, 2000 WL 140751 (N.D. Tex., Feb. 4, 2000); *cf. Potter v. Fraser*, 2011 WL 2446642, at *4-6 (D. N.J., June 13, 2011) (holding that the plaintiff did not adequately plead a Fourteenth Amendment claim because he did not specify any withdrawal symptoms, complaints to jail officials, or that officials ignored his complaints).

[111] *Davis v. Carter*, 452 F.3d 686 (7th Cir. 2006).

[112] *Id.* at 696.

IV. CONCLUSION

Denied access to MAT at all levels of the criminal justice system violates the Americans with Disabilities Act and the Rehabilitation Act where the denial is pursuant to a blanket policy prohibiting MAT or is carried out on a case-by-case basis without performing the required individualized evaluation. Attempts to justify denied access to MAT on the grounds that MAT is "substituting one addiction for another" or is not a valid form of treatment should not defeat an ADA or Rehabilitation Act claim, as such views run counter to objective evidence concerning treatment for opiate addiction. Arguments about the security risk posed by MAT also should fail, even in prisons and jails, where correctional officials can employ measures to avert diversion and other safety concerns.

To the extent that some criminal justice agencies deny access to MAT pursuant to a larger policy prohibiting the use of any prescribed controlled substance, such policies also are likely to violate the ADA and Rehabilitation Act, due to their disparate impact on opiate-addicted individuals receiving or in need of MAT. The failure to grant individuals who need MAT an exemption from such policies as a "reasonable accommodation" also would likely violate these anti-discrimination laws. Prisons and jails also risk violating the United States Constitution's Eighth Amendment prohibition on cruel and unusual punishment or Fourteenth Amendment Due Process clause when they force individuals on MAT to detoxify without appropriate medical supervision or delay the provision of MAT.

About the Legal Action Center

The Legal Action Center is the only non-profit law and policy organization in the United States whose sole mission is to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records, and to advocate for sound public policies in these areas. For nearly four decades, LAC has worked to combat the stigma and prejudice that keep these individuals out of the mainstream of society. The Legal Action Center is committed to helping people reclaim their lives, maintain their dignity, and participate fully in society as productive, responsible citizens.

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